PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at HMP & YOI Holme House in June 2012

Report by the Prisons and Probation Ombudsman for England and Wales

March 2013

This is a report of an investigation into the circumstances surrounding the death of a man in June 2012. He was discovered hanging in a cell in the healthcare centre at Holme House prison. He was 32 years old. I offer my condolences to his family.

The investigation was carried out by an investigator. The local Primary Care Trust appointed a clinical reviewer to carry out a review of the clinical care the man received at Holme House.

The man was recalled to Holme House two weeks after being released on licence from a previous sentence. He died after only two days after his return to prison. The investigation focused on two main issues – the prison's response to his drug treatment needs and the quality of suicide and self-harm arrangements.

The investigation raises serious concerns about how the man's addictions were managed. He was refused methadone on arrival at Holme House, despite having received it previously at the prison, in the community and in police custody. A specialist in substance misuse concludes that the decision not to prescribe him methadone at Holme House was flawed. I agree. While there was an understandably cautious approach taken by medical staff about how methadone might interact with other drugs he might have taken, there appears to have been errors in procedure which prevented him receiving appropriate support. Although suicide and self-harm monitoring procedures were started after he cut himself on 23 June, I am not satisfied that the risk he posed to himself was appropriately assessed when he first arrived on 21 June and there was inadequate subsequent observation and staff engagement. There are some important lessons for the prison to learn from this tragic case.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2013**

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SUMMARY

1. The man was released on licence from Holme House on 12 June. After allegedly committing a further offence, he was recalled to prison. He appeared at court and returned to Holme House on 21 June, just nine days after his release.

2. The man had received daily methadone medication in the prison as part of a planned methadone maintenance programme to combat addiction to heroin. His medication continued after he was released and he received methadone under supervision at a pharmacy. After his arrest he spent a night in police cells, where he was also given methadone.

3. When the man had his urine tested for drugs when he arrived at Holme House on 21 June, the results did not indicate that he been taking methadone. As a result the prison doctor decided not to prescribe him methadone, although he correctly protested that he had been receiving it for some time.

4. During his short time at Holme House, the man continued to request methadone. A second drugs test on the morning of 23 June was positive for methadone, which cast doubt on the accuracy of the first test. However, because of the other drugs that were recorded as being in his system, and concerns of how they mixed with methadone, the doctor decided to delay prescribing methadone.

5. The man had become increasingly distressed and agitated about not receiving methadone. He cut his face and was placed on suicide monitoring procedures. He told prison staff that if he was not given methadone, he would take his own life.

6. Less than three hours after making this threat, the man was found hanging in his cell in healthcare at around 7.10pm. Despite attempts by staff, he could not be resuscitated and was pronounced dead by paramedics at 7.30pm. At 9.10pm a prison doctor certified his death

7. This report makes five recommendations. One concerns the prescription of methadone and the other accuracy with which drug tests are interpreted. The other three refer to the suicide monitoring process.

THE INVESTIGATION PROCESS

8. An investigator visited Holme House on 28 June and met the Deputy Governor and the Safer Custody team. She obtained copies of relevant prison documentation relating to the man and visited the cell where he died.

9. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with any relevant information. No other witnesses came forward. She was also provided with statements taken by police, including one from a prisoner who had briefly shared a cell briefly with the man on the day he died.

10. The local Primary Care Trust (PCT) appointed a clinical reviewer to undertake a review of the clinical care the man received while at Holme House. He is a prison GP advisor to the National Treatment Agency for Substance Misuse and the clinical lead for the Royal College of General Practitioners' part two certificate in substance misuse. He undertakes regular clinic work in both prison and mainstream primary care settings.

11. The investigator identified 11 interviewees and notified the prison of these on 13 July. Despite the length of notice given, when she and the clinical reviewer arrived at the prison on 14 August, a number of staff were unavailable. We were told this was because of annual leave, special leave and sick leave. One doctor did not give any reason for not attending the interview and another member of staff has since left the Prison Service. Over the two days only four interviews were able to be carried out. However, they were able to obtain sufficient information from the staff they interviewed and the documentation available.

12. The clinical reviewer interviewed a further member of healthcare staff separately on 6 September.

13. The Coroner for Teesside was informed of the investigation and the investigator requested a post-mortem report. A copy of the toxicology report remained outstanding at the time of writing this report.

14. One of the Ombudsman's family liaison officers contacted the man's father, mother and partner to invite them to be involved in the investigation process. The investigator and family liaison officer met the man's father and step-sister on 15 August, who had the following issues and questions which they wished the investigation to cover:

- Why was he left alone when he was at risk of harming himself?
- What level of observations was he on and what was the last time he was checked?
- Who discovered him?
- Were the required observations and interactions carried out correctly?
- Did the prison consider that he said he had been recently bereaved?
- What care notes had been taken and were the required actions carried out?

- Had he been feeling low for any period of time and was he displaying any signs of frustration or depression?
- Should he have been given any other medication to help him calm down?
- What did the toxicology results indicate?
- What were the actions of staff responsible for his care?
- Why was he in a cell where there were ligature points?
- They wanted to have clarification of how he had hanged himself and whether he should have been allowed bed sheets.
- Why had his father been referred to as his uncle by the prison?
- The man's father said the family had serious concerns that his son did not receive methadone. He believed his son would still be alive if he had been given the methadone he had repeatedly requested.

15. During the consultation process the man's family were given a copy of the draft report. They commented that they were originally told that he had scratched his face with his fingernails rather than a razor, and thought that using a razor indicated his risk of self harm.

16. The family also felt that more should have been done to observe and support the man after he said he was going to kill himself. They were also unsure why a senior officer had decided to check on him when he did and why he was not alerted to his cell earlier.

HMP HOLME HOUSE

17. Holme House, near Stockton on Tees, opened in 1992. It holds up to 1212 prisoners with a mixture of young adult offenders and adult males on remand or sentenced from courts in the North East of England. The accommodation consists of seven houseblocks.

18. Holme House has an inpatient healthcare centre with 28 inpatient cells. It has 24 hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection was held in July 2010. The Chief Inspector of Prisons, in his introduction to the report, noted that against a largely positive backdrop "the prison faced some significant challenges. Drugs were a major issue, despite the prison tackling this robustly". The Chief Inspector also reported that the "integrated drug treatment system had been recently introduced but there was a need for improved staffing and better coordination".

20. The report also noted that

> "The self-harm and suicide strategy was cohesive and comprehensive. A bi-monthly safer custody forum repeated much of the violence reduction steering committee agenda. Monitoring and analysis of information was basic but good ongoing attention was paid to recommendations from death in custody reports. Levels of self-harm and the number of prisoners on open assessment care in custody and teamwork (ACCT) documentation were relatively low.
>
> The quality of ACCT documents was generally good, with numerous examples of positive engagement. Care maps were sometimes limited and some case reviews lacked sufficient, and suitably multidisciplinary, input, although there was good engagement with external support staff."

Independent Monitoring Board (IMB)

21. The IMB is made up of independent, unpaid members of the local community who help ensure standards of care and decency are maintained. In their last report for the period 1 January to 31 December 2011, the IMB noted:

> "As part of the Board's role, members attend ACCT reviews and sign ACCT documents as appropriate. The standard of entries by staff in these documents has greatly improved. There is now a full quality check run on ACCTs at closure."
>
> "Because of demands on prison staff, it is not always possible for all interested parties to attend ACCT reviews. There is now a system in place whereby a list of all open ACCTs is published electronically every day, with review dates."

Suicide and self-harm monitoring

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Previous deaths at Holme House

23. There have been four deaths at Home House so far in 2012. Two were from natural causes. The other self-inflicted death is still being investigated. In 2011 there were also four deaths. Two were natural causes and two were self-inflicted deaths. The investigation into one of these deaths highlighted issues surrounding safeguarding a prisoner who has been recalled to prison and who had mental health issues.

KEY EVENTS

24. The man, who had previously been in prison a number of times, was released on licence from Holme House prison on 12 June 2012. He had been prescribed 20mg of methadone a day while in Holme House and arrangements were made with medical services for him to continue to receive this prescription in the community.

25. On 16 June, the man allegedly committed a further offence. As a result, his licence was revoked and he was recalled to prison. He was arrested on 20 June and taken to a police station, where he spent the night before his appearance at Magistrate's Court on 21 June.

Events leading up to the incident

26. The Person Escort Record (PER) indicated that the man was prescribed methadone, a substitute for heroin. The police confirmed that he had received 20mls of methadone at 2.55am on 21 June.

27. The police completed a self-harm warning form. The police wrote on the form that the man said he intended to harm himself and that he became tearful when talking to the custody officer as he said his father had died and he had not been to put flowers on his grave. (It was not the case that his father had died although he had been bereaved.) He said he felt like hanging himself because there were people in Holme House who were out to get him. It was noted that he displayed poor eye contact and a reluctance to talk.

28. The fact that the police had completed a self-harm warning form was noted in the PER at 9.50am. At 9.58 am the police also noted in the PER that the man had banged his head on a wall. He refused medical treatment, but as a result he was moved to a shared cell which had a camera. At 2.46pm a police custody officer noted that he had a red mark on the side of his head. He was again offered medical treatment but refused.

29. At court, the man was remanded in custody till 5 July, and went to Holme House. The PER and self-harm warning form accompanied him. A nurse assessed him in reception and noted that he needed to see a doctor for his substance use problems and recent injuries. He said he had been hit by a car two days earlier and had bruises to his head and ears but had not had his injuries examined.

30. It is not clear what documents the nurse used when he assessed the man, although he said at interview that he knew a self-harm warning form had been raised. However, the first reception screening form, completed in reception at 5.11pm (but unsigned) did not record any episode of self-harm in the section entitled 'History of Self-Harm'. There is also no entry in the section which asked for details of the most recent attempt of self-harm. In the section below it is recorded that he had no thoughts of harming himself and no suicidal thoughts.

31. The man told the nurse that he had been on methadone, and that he had 30mls the day before. (It was 20mls.) He also said that his paternal grandparents "had fatal chest cancer". The nurse carried out a urine test to determine what medication was in his system. He tested negative for buprenorphine (used to treat opiate addiction), opiate, cannabinoid (cannabis), cocaine, amphetamine and methadone. However, he tested positive for benzodiazepine (a treatment for anxiety). At interview the nurse said that there was no chance that there had been an error in reading the test results. He said that despite a suicide warning form accompanying the man from the police, he knew him from his previous time at Holme House and he did not think that he was feeling suicidal.

32. A Cell Sharing Risk Assessment (CSRA) was completed to assess whether the man would be a risk to other prisoners if he shared a cell. It was noted in the document that he was not to be located on houseblock one as he had issues with another prisoner there. He was regarded as standard risk and able to share a cell.

33. A prison doctor examined the man, who told her he had been "run over" two days earlier. She noted that he had superficial bruising and scrapes to his forehead and cheek, but there were no other injuries to his limbs to indicate he had been hit by a vehicle. He told her that he had last had methadone the day before, but that he had just had a urine test that had tested negative for this. She said he could not understand this as he had not used benzodiazepine for a week, but had taken methadone. In her entry in the medical records, she does not refer to any information she had about him or whether she had seen any documentation.

34. The doctor noted that the man "appeared to be under the influence". He asked for methadone and pregablin (a pain killer), but she refused both. She admitted him to the healthcare inpatient unit because he appeared intoxicated and she wanted to monitor his possible head injury.

35. When he got to the inpatient unit 45 minutes later, the man told a nurse that he would stab the next person who entered his cell. She submitted a Security Information Report (SIR) and made other healthcare staff aware of his threats. It was subsequently noted in the SIR that he had calmed down and was being appropriately managed by staff. The nurse said during her interview that he had said he had taken a large amount of benzodiazepine before coming to prison.

36. Later that evening, a nurse noted in the man's medical record that he claimed to be on 30mls of methadone, which he had last had the day before, but that there was no evidence of any drug, apart from benzodiazepine, in his urine. She also noted that he had said he had been involved in a car accident, but had no injuries to any limbs. The plan was to monitor him on four hourly observations for any head injury. She also noted that he "appeared to be under the influence". She wrote that he should be monitored under National Drug Treatment guidance and be assessed on the Opiate Withdrawal Scale. He needed a second reception screening, a review from a doctor and

confirmation that he had been prescribed methadone and pregablin. A substance use review was due the next day and he was to be given symptomatic pain relief if he needed it. There is no record that anyone telephoned his GP or requested his community records for further information at this stage. (Checks were made the next day about his methadone prescription.)

37. That night, a nurse examined the man as part of the observations for his head injury. He told her that he had sustained injuries by jumping out the way of a car. He said he could not remember much more about it, other than he scraped his face and twisted his back. She recorded his blood pressure and pulse rate. She noted that his right pupil was slightly larger than his left, but he assured her that this was usual. His speech was slurred, but he appeared orientated to time and place and was able to answer all her questions.

38. The investigator spoke to a Listener who saw the man when he arrived in reception at Holme House. (Listeners are prisoners trained by the Samaritans to support other prisoners.) The Listener said that he had been asked to sit with him as he had seemed "hysterical" about a home issue. Because of confidentiality, the prisoner was unable to go into detail. He said that the man had some food and a cup of tea and seemed to calm down. The Listener stayed with him for a further 20 minutes and said that he had not thought that he intended to harm himself and that the main issue he had were problems outside prison and he was familiar with Holme House.

39. The next morning a nurse from DART (the Drug, Alcohol Recovery Team) saw the man and also carried out a secondary reception health screen. He said he felt very down, that he was estranged from his children and had recently lost three close family members. She said he appeared very upset and said that he had been depressed in the past, although was not on any medication for this. He said he had no thoughts of harming himself at that time and an Assessment, Care in Custody and Teamwork (ACCT) plan was not considered.

40. A nurse spoke to the inpatients' nurse about the man, who said he had been referred to the mental health team. It was also planned to repeat the urine test. It was noted that he again said that he had been on 30mls of methadone daily, and that he had had supervised consumption at a local chemist in Middlesbrough. He said that when he was in police custody the medication was collected for him. Police records confirm this to be the case. He said that he had used benzodiazepine and heroin in the last month.

41. A nurse assessed the man using the Opiate Withdrawal Scale. She noted that he was not restless, his pupils appeared the right size, he had aching joints but no tremors, no yawning. He was noted to be feeling increasingly irritable and anxious.

42. The man complained about pain in his left leg. He said he had injured it after falling from a building and although it was painful he was not on any

medication for this. The nurse noted that she would arrange for him to see the doctor. She decided to review him again in five days.

43. Another nurse also saw the man that day and wrote in his clinical record that he had become tearful when discussing family issues, although had no thoughts of harming himself. She noted that he 'does not warrant an ACCT'. At interview she said that he had maintained good eye contact, an open body posture and was very focussed on getting methadone. He said he had no thoughts of harming himself but was very cross that he had not received methadone. He said he had fallen out with his family which had upset him. She maintained that she had no doubt that an ACCT was not warranted.

44. Later that morning, a healthcare administrator contacted the medical services for confirmation about the man's medication. They agreed to fax this through to healthcare. The administrator also contacted the chemist where he received methadone and was told that he was prescribed 30mls of methadone daily, under supervised consumption. His latest script started on 13 June, and he received his last dose from them on 18 June. Between those dates he had not missed any doses.

45. An hour later the man was seen by a doctor. He told him he was "feeling a bit rough". He recounted that he had been hit by a car, but had no headache, had not been vomiting and had kept well overnight. He told the doctor that he previously took omeprazole (for acid reflux) gabapentin (for seizures) and methadone. The doctor noted that he had last taken methadone on Wednesday (two days previously), but none had showed in his urine. The doctor said that he was well enough to be moved to a houseblock and that he should not be prescribed gabapentin until 'confirmed' and no methadone as it had not showed in his urine test.

46. The same day the man completed his induction. As he had been at the prison very recently he was given a 'fast track' induction. He was given information about the Listener scheme and the diversity policy was explained to him.

47. That evening, at 7.30pm, the man spoke to a nurse. He told her the urine test he had in reception could not be correct as he had been given methadone while in police custody. She wrote in the clinical record:

> "Urine test strips shown to doctor, who agrees that the test strip does appear to show positive but due to strong positive of benzodiazepine he is not happy to prescribe on safety issues."

48. It is not clear whether the nurse took a new test or the strip from his original test in reception. The results indicated a presence of benzodiazepine, buprenorphine, cannabinoid, cocaine and methadone.

49. A doctor said he would assess the man the next morning. He was unhappy about this, but aware that he would be seen the next morning and that he could request ibuprofen and paracetomol for symptomatic relief if he felt he

needed it. A nurse noted no obvious signs of withdrawal and that he would need another urine test.

50. A further urine test was taken the next morning. The results were negative for cocaine, amphetamine and opiate, but positive for buprenorphine, benzodiazepine, cannabinoid and methadone.

51. A nurse assessed the man's drug withdrawal. She did not note any concerns in the medical record. A doctor saw him ten minutes later. He complained of diarrhoea, general aches and insomnia. The doctor noted that he looked well and there were no signs of drug withdrawal. He diagnosed early precipitated withdrawal. They discussed his drug use and the urine test results. He said he did not know where the buprenorphine had come from. The doctor advised him that he could take symptomatic pain relief and arranged for a further review on Monday 25 June. There is no record of his response to this.

52. In his statement to police, the doctor said that the man had seemed well, was coherent and had good eye contact. He did not appear under the influence of drugs or that he was withdrawing from drugs. He told the doctor that he was "rattling" but the doctor said again that he was showing no signs of withdrawal. The doctor told police that even if he had seemed to be withdrawing he would not have given him methadone because of the risk of overdose. The doctor also said that he seemed "fairly cheerful" at that time. This is contrary to what he told the investigator at interview, when he said the man was aggressive and shouting and swearing.

53. The doctor said at interview that there had been two recent deaths at another prison because of methadone overdose. This had made him cautious and to seek advice from his mentor (who runs regular clinics at Holme House) about prescribing methadone when the man had tested positive for other drugs. He thought the best course of action was to monitor and observe him and offer him support.

54. Later that day at 2.26pm, the man moved to houseblock 4 where he shared a cell with another prisoner.

55. On 11 July, the police took a statement from a prisoner who had shared a cell with the man when he was on houseblock 4. In his statement the prisoner said that the man had appeared anxious and frustrated because he wanted medication (methadone) but was not given any. He put his belongings in the cell and then asked the prisoner if he had any Subutex (a trade name for buprenorphine). The prisoner said he did not, so the man asked where he could get some in the prison. He said he did not know but perhaps he should ask the wing cleaners (prisoners).

56. The prisoner said that the man then left the cell for about ten minutes. When he returned he asked him who might swap his tobacco for food. The prisoner said he did not know who had food. He said in his statement that he knew that the man intended to swap food for Subutex, as he had said that he had found a prisoner who was not a smoker but willing to swap Subutex for food.

He said that he did not think that the man was able to obtain any Subutex as there was not much time left until the end of association (when prisoners are able to mix with each other on the houseblock).

57. Once they were locked in their cell, the prisoner said the man found it hard to settle. He did not put his property in his locker or make his bed. He constantly paced the cell with his head in his hands. The prisoner recalled that the man said he knew a prisoner had Subutex and was annoyed that he would not give this to him. He said he was "going to slash the lad" the next morning.

58. At 4.25pm a Senior Officer (SO) heard the man's cell door being kicked. In a statement he made to the police, he said that two officers went to the cell and saw that he was bleeding from a wound to his face and there was a razor blade on the floor. The SO went to the cell and asked what had happened. The man said he was "rattling" due to not being prescribed methadone. The SO said he seemed agitated due to drug withdrawal. He asked staff to call for a nurse to attend immediately.

59. At 4.35pm a doctor arrived at the cell with a nurse. The man complained of drug withdrawal and asked to be given methadone. He said that he thought he had moved from healthcare to begin drug treatment on the wing and was upset this was not the case. He said that if he did not get his medication he would end his life.

60. The doctor reiterated his earlier advice to the man about symptomatic pain relief and that he would review him on Monday. The doctor also explained that he would not die from withdrawing, but prescribing methadone when he already showed positive for benzodiazepine could be fatal. He became very agitated and demanded methadone. He said he had not taken benzodiazepine and could not understand how he had tested positive for it. He said he thought he had two options, "to self-medicate or self-end, and he would not be self-medicating". The nurse said at interview that he did not think that he was suicidal, but angry at not being prescribed methadone.

61. The doctor said it would be better if the man returned to healthcare. He was unhappy about this and said he would "smash up" as he had thought he would be moved onto another houseblock to begin detoxification and receive his medication.

62. The doctor said in his statement to police that he knew it would be dangerous to prescribe the man methadone, as the urine test had showed he had other drugs in his system.

63. The prisoner's account of these events is that after they were locked in their cells the man began talking about cutting himself because he would "get seen quicker". He said he was going to cut his face and the prisoner told him not to be daft. He sat on his bed with a razor blade from a disposable razor, but did nothing at that stage. The prisoner then went to the toilet which was behind a partition wall.

64. When he returned to the main part of the cell, the prisoner saw that the man had cut his face, but it was only a scratch. He then cut the right side of his face. The prisoner pressed the cell bell to alert staff. He said five to ten minutes later an officer responded and looked through the observation panel. He told him that the man had cut himself. He said a further five to ten minutes passed before another officer and a doctor arrived.

65. The prisoner said in his statement to police that the man had asked the doctor for methadone straight away. The doctor explained that he could not be prescribed this because he had Subutex (buprenorphine) in his system and that he should return to the healthcare inpatient unit. He said the man seemed devastated that the doctor would not prescribe him methadone and said that he would kill himself. He asked for another urine test to prove he did not have Subutex in his system, but the doctor refused. The doctor said it was dangerous to take Subutex and methadone together. The prisoner said this was well known among prisoners.

66. The SO opened an ACCT for the man at 4.15pm. He telephoned another SO, who was the orderly officer that day (the manager responsible for the operational running of the prison) to inform him that he had opened an ACCT for the man and to request a log number (all ACCTs are logged centrally).

67. The SO noted on the front cover of the ACCT that the man should be on hourly observations until he had an assessment. He noted that he had cut his cheek because he had not been prescribed methadone. The SO also completed an immediate action plan which was that he should be moved to the inpatient unit in healthcare and observed by staff there. The man said he did not want to see a Listener or use the telephone. Apart from the on-going record of observations, no other part of the ACCT document was completed.

68. Once he had moved to healthcare, the man was allocated to cell 15, a single cell. A nurse noted that he was on hourly observations, that he had not been issued with any medication and required no treatment to his face as the wound was minor. At 5.00pm she noted that he was lying on his bed watching television. She did not speak to him.

69. Just before 6.00pm, a nurse responded to the man pressing his cell bell and he asked for his cut to be cleaned. He could not be unlocked at the time as the prison was in patrol state (when cells are usually only unlocked in an emergency or with the orderly officer and other staff present) so she went to the cell and told him to wash the cut with clean water. She noted that the cut was not “actively bleeding”. He became verbally aggressive and she gave him a behaviour warning.

70. The man was checked again at 6.00pm and 6.30pm. On both occasions he was recorded as watching television. There is no record of any conversation or communication between him and staff.

71. At about 7.10pm Officer A, who was responsible for the constant supervision of another prisoner nearby (who was asleep), noticed that the man had become very quiet and went to his cell to check on him. He saw that he had tied a bed sheet to the frame of the bed, which was fixed to the ground. The sheet was passed over a low wall which separated the toilet area. He was sitting slumped on the other side of the wall, with the sheet tied around his neck.

72. The officer immediately called out to staff who were close by in healthcare for assistance and entered the cell. Nurses responded to the call. Nurse A wrote in her statement that she heard Officer A call out "cell 15". Nurse B recalled that when she entered the cell she saw the man slumped on the floor and his head was resting against the partition wall.

73. Officer A cut the ligature from the man's neck using his anti-ligature knife, which all officers carry, and lowered him flat to the floor. He recalled in his statement that his eyes were open, but there was no movement. Nurse B radioed the Control Room to raise an emergency code blue (indicating a life threatening emergency). The orderly officer heard the emergency call over the radio and went immediately to healthcare.

74. The times of events differ in staff accounts. Officer B and the orderly officer put the time at 7.10pm. Officer A said it was 7.15pm, while the nurses said it was 7.00pm. However, the prison log agreed that the call was made at 7.10pm and the ambulance was called at 7.12pm.

75. Both nurses began to administer cardiopulmonary resuscitation (CPR) while the other two nurses went to collect the emergency equipment, including an ambu bag (to help administer breaths) and a defibrillator. The man was turned on his side to clear vomit in his airway. The defibrillator was applied to him, but it read that a shock was not advised. Nurse B continued to give breaths and Nurse A chest compressions.

76. Officer B, who had been close by in reception, responded to the call and said it took him no more than 30 seconds to arrive at the cell. As soon as he arrived there he radioed for an emergency ambulance (which was called at 7.12pm). He then picked up the man's identification card and radioed the Control Room again to give them further information.

77. The ambulance arrived at the prison six minutes later, at 7.18pm. The paramedics examined the man and attempted to resuscitate him, but they pronounced him dead at 7.30pm. They left the prison at 8.08pm. Officer B and another officer stood outside the cell door while waiting for the police to arrive and began to keep a log of anyone who entered the cell and the reason why. A prison doctor arrived at the cell at 9.09pm and certified death a minute later.

78. At 9.40pm a debrief was held for the staff who were involved in the incident. It was noted that a member of the IMB raised an issue over confusion about the doctor's attendance. No further information is given in the debrief minutes but

we would agree that it was unnecessary if that was the point being raised. (The prison accepted a recommendation about this in July this year.) No other issues appear to have been raised.

79. Staff were given the opportunity to speak to a member of the Care Team if they felt distressed and all the prisoners in healthcare were checked and given the opportunity to speak to a Listener or Samaritan. The prisoner who was on a constant watch had his ACCT reviewed.

80. The prison's family liaison officers went to visit the man's partner, who was listed as his next of kin, at about 10.20pm. They arrived at the address given shortly afterwards, but were told that she was not there. The liaison officers were given another address and they arrived there at 10.40pm, but the house was in darkness and they could not get a response. The Deputy Governor advised them to try again the next morning.

81. At 9.00am the next morning the liaison officers checked the man's next of kin details again. Eventually they managed to locate another family member, his probation officer and solicitor. They first went to his aunt's address, but got no reply. They then arrived at another address which was noted in the prison records as his uncle. This was incorrect and it was his father. The liaison officers apologised for the confusion and any distress cause by the error. They explained that his son had died.

82. Later that day one of the liaison officers was able to contact the man's partner. She was told that he had died and they arranged to give her telephone number to his father so he could call her.

83. A post-mortem examination was carried out on 25 June. The cause of death was pressure on the neck due to hanging. The examination also recorded seven superficial incisions to the man's cheek, minor and old skin injuries, a scar in the posterior wall of the left ventricle and granulomas (inflammatory cells often associated with drug use) in the liver. He also had a loose rib, with a related bruise. The toxicology report is still not available.

84. The funeral was held on 6 July. In line with national guidance, the prison contributed towards the cost.

85. The clinical reviewer was unable to interview the reception nurse until 6 September. He said that he had cared for the man previously and knew him well. He confirmed that he undertook the first night assessment. He did not personally take the urine sample, which was taken by a healthcare assistant. However, he said that he would have seen the urine test to check that it showed negative for all substances apart from benzodiazepines. He said that the negative test meant that methadone was not present in the man's system, rather than an alternative explanation that the test was interpreted incorrectly. However, he considered that even if he had tested positive for methadone, he would not have been prescribed it, as the test also showed the presence of benzodiazepine.

86. The nurse said there had been a recent shift away from prescribing methadone at Holme House because of recent deaths at Durham prison. He said this shift had been driven by the clinical lead because of perceived risks to prisoner safety.

ISSUES

Methadone prescribing

87. The investigation found that the man had been prescribed methadone during his period in custody at Holme House which ended nine days earlier, and that he was on supervised consumption while in the community. Police records also confirm that he was given methadone while at the police station.

88. The clinical reviewer notes that the man appeared distressed that he was denied his prescription. He concludes that it was a reasonable clinical decision to withhold medication on the evening on 21 June, when he arrived at the prison, as a clinical assessment by a doctor noted that he "appears under the influence". There is no further explanation of what was meant by this and we note that he had been in police custody for some time. The clinical reviewer concludes that on the balance of probabilities, he was starting to withdraw from methadone and that he was fearful of the effects of a withdrawal. As a result, opportunities were missed on those dates to continue the prescription for methadone maintenance.

89. The clinical reviewer notes that prescribing clinicians are understandably anxious that their prescribing could contribute to an opiate related overdose. We agree it is appropriate to be cautious. However, the man was receiving only a relatively low daily dose of methadone. The clinical reviewer considers that this could have been administered as a split dose for the first two days if caution was needed. Had this been done he would have been less distressed and therefore less likely to inflict his own death. The clinical reviewer suggests that there is a need for prison based GPs working with drug users to undertake accredited specialist training in substance misuse and we agree that this would be helpful.

The Head of Healthcare should ensure that prison based doctors working with drug users undertake training (Royal College of General Practitioners part 1 and 2 certificates) in substance misuse.

90. We and the clinical reviewer are concerned that the initial urine test taken on 21 June was positive only for benzodiazepines, yet subsequent tests taken on 22 and 23 June were positive for multiple drugs.

91. There can only be three explanations for this. The first is that there was an error in the test strip, the second that there was an error in the processing or interpreting of the urine test result and the third that the man had managed to get access to a range of drugs and take them in the prison.

92. At interview the reception nurse said there could not have been an error with the test strip, but he said this had occurred on some occasions. The clinical reviewer believes that if that was the case, he would have expected to see errors highlighted in other tests taken at the same time for other prisoners and this to be mentioned to the investigator.

93. The second possibility is that there was an error in reading and interpreting the test results. Both the reception nurse and the Head of Healthcare (when asked about this informally) said this could not happen. They both said that the most likely explanation was that between arriving at the prison and the second urine test, the man was able to ingest buprenorphine, methadone, cocaine and cannabis. If that had happened we would have expected that he was sufficiently intoxicated for staff and other prisoners to notice, but there was no indication of this.

94. This explanation is also inconsistent with the prisoner's account of the man's attempt to obtain Subutex while sharing a cell on Houseblock 4. He reported that he was anxious to buy only this drug, but was unsuccessful. The clinical reviewer also concludes that it is extremely unlikely that he would have no detectable methadone in his system on 21 June, given that he was in receipt of a regular script and had received a dose at 2.55am on 20 June. Some staff would prefer to accept that he was able to obtain a number of different drugs on his first night in prison, rather than the possibility that there was a mistake. The clinical reviewer considers, and we agree, that the most likely explanation is that there was an error in either the process of conducting, or interpreting the urine test on 21 June, otherwise it is very difficult to explain the absence of methadone in the test result. It is also unlikely that if he had had access to illicit drugs, he would have presented as distressed, frustrated and agitated, as he was. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff receive refresher training in conducting urine tests for drugs and interpreting the results.

ACCT Management

Assessment of risk

95. Prison Service Instruction 64/2011 outlines different risk factors associated with suicide and self harm. Of the triggers listed, the man was a drug addict, had recently self-harmed, said he had recently been bereaved, was early in custody and had been recalled to prison for breach of licence. He had also told police he intended to kill himself.

96. The man made threats to harm himself in police custody, and then self-harmed by hitting his head against the wall. Police recorded this information on the PER and on a suicide self-harm warning form. Both these documents were seen by reception staff, and the nurse conducting the reception health screen. No proper consideration appears to have been given to the risks that he presented and the police had identified. Too much emphasis was placed on staff knowledge of him from his previous time in custody and him saying he would not self-harm.

97. Even had the number of risk factors not been considered, the PSI clearly states that; *"Prisoners who self-harm must be managed using the ACCT procedures"*. It goes on to read;

"*Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."*

98. Had an ACCT been opened in reception, an assessment by a trained assessor would have taken place within 24 hours and the man would have had a case review. He would also have a caremap, intended to address the factors that were causing him distress. We consider there were a range of risk factors which indicated the need to open an ACCT in reception and more weight should have been given to them rather than relying on his personal presentation.

The Governor should ensure that an ACCT is opened whenever a prisoner has recently self-harmed or expressed suicidal intent.

The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, including information from suicide and self-harm warning forms and PERs.

ACCT

99. An ACCT was opened on 23 June, after the man cut his face with a razor. The immediate action plan was completed and he was offered the support of Listeners and the opportunity to make a telephone call but declined both. He was moved to the healthcare centre. It is not apparent that any consideration was given to the fact that he was moved from a shared cell on the wing to a single cell in the healthcare centre. It was decided that he would be observed hourly until he had been fully assessed, which should take place within 24hours of the ACCT being opened.

100. We consider that hourly checks for someone who has just self-harmed, is voicing suicidal intent and has not yet had an assessment is not sufficiently frequent. Often staff take a cautious approach until a full assessment and multi-disciplinary review can be conducted. The purpose of the immediate action plan is to keep the prisoner safe until this can happen. The checks that were made were too predictable. They were at 5.00pm, 6.00pm, with an additional check at 6.30pm and then he was discovered soon after 7.00pm. No one during that time made any attempt to speak to the man to check on his wellbeing and it is simply recorded that he was watching television. The purpose of placing someone on an ACCT is not just to ensure prisoners' physical safety through observations, but also to provide emotional support.

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The Governor should ensure that ACCT observations are of sufficient frequency and at unpredictable times, and that staff actively engage with prisoners at risk.

CONCLUSION

101. The man had been prescribed methadone consistently during his previous period in custody at Holme House, less than a fortnight earlier, and it was confirmed that he had received a script while in the community, before he was recalled to prison. When his urine was tested in reception there was no indication that he was taking methadone so this was not prescribed. We consider it likely that test was carried out or interpreted incorrectly as there is clear evidence that he had recently taken methadone which was not indicated. No further investigations were made, although he was extremely anxious. There was an insufficiently flexible approach to meeting his needs.

102. It is also a concern that an ACCT was not opened when the man arrived at the prison. Apart from a number of known risk factors such as substance use problems, bereavement, family estrangement, feeling low, and that fact that he was a recalled prisoner, there was a clear self-harm warning form from the police indicating recent self-harm and active suicidal feelings. We do not consider his risk was rigorously assessed taking into account all the known risk factors. Once an ACCT was opened observations were poorly conducted with little evidence of active staff engagement to provide support.

RECOMMENDATIONS

To the Governor:

1. The Governor should ensure that an ACCT is opened whenever a prisoner has recently self-harmed or expressed suicidal intent.

   The prison accepted this recommendation. They said - A Governors Order will be issued immediately and a system of annual reminders of staff responsibility with regard to the management of the ACCT process will be put in place. A Governors Order will be circulated annually to all staff in the establishment.

   The need to do this will be emphasised in all scheduled Safer Custody/ACCT training and has been supported by the communication of the QTL Bulletin throughout the establishment.

2. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide, including information from suicide and self-harm warning forms and PERs.

   The prison accepted this recommendation. They said - A system of annual reminders of staff responsibility with regard to the management of self-harm warnings will be put in place. A Governors Order will be circulated immediately and annually thereafter to all staff.

   All relevant departments (Safer Custody; Reception; Video Link; Custody Office; Offender Management Unit; Residential; First Night Centre and Induction) have been made aware that all newly arrived prisoners are at a heightened risk of suicide/self-harm.

   A member of the Safer Custody Department will see all licence recalls the day following reception or the next working day or, in the case of being informed by the Custody Office, the next day or next working day following being informed.

3. The Governor should ensure that ACCT observations are of sufficient frequency and at unpredictable times, and that staff actively engage with prisoners at risk.

   The prison accepted this recommendation. They said - A Governors Order will be immediately circulated to all staff reminding staff of the need to use appropriate levels of frequency of observations stressing the need for these observations to be unpredictable. All observations to include meaningful interaction if appropriate.

   ACCT documentation is checked daily by Holme House Operational Managers.

To the Head of Healthcare:

4. The Head of Healthcare should ensure that prison based doctors working with drug users are encouraged to undertake training (Royal College of General Practitioners part 1 and 2 certificates) in substance misuse at the earliest opportunity.

   The prison accepted this recommendation. They said - All prison based doctors will be encouraged to undertake training to obtain Royal College of General Practitioners part 1 and 2 certificates in substance misuse.

5. The Head of Healthcare should ensure that healthcare staff receive refresher training in conducting urine tests for drugs and interpreting the results.

   The prison accepted this recommendation. They said - Refresher training will be provided to all staff conducting urine tests.